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	HFD0009	A. BUILDING _____ B. WING _____	12/28/2007

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I 000	INITIAL COMMENTS A licensure survey was conducted from December 27, 2007 through December 28, 2007. A random sample of three residents were selected from a population of five females with various disabilities. The findings of this survey were based on observations at the group home, interviews with one resident and group home staff, review of clinical and administrative records to include the facility's unusual incident reports and investigations.	I 000		
I 090	3504.1 HOUSEKEEPING The interior and exterior of each GHMRP shall be maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. This Statute is not met as evidenced by: Based on observation, the GHMRP failed to ensure the interior and exterior of the GHMRP was maintained in a safe, clean, orderly, attractive, and sanitary manner and be free of accumulations of dirt, rubbish, and objectionable odors. The findings include: Observations of the GHMRP 's environment on December 28, 2007 at approximately 12:13 PM revealed the following: Interior	I 090		

/s/ per Evette Moore
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE DIRECTOR OF RESIDENTIAL SERVICES (X6) DATE 1/25/08

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I 090	Continued From page 1 1. The cabinet drawer located in the kitchen near the stove was missing. 2. The bathroom located on the upper level was observed to have rust build up inside the sink where the water flows through. 3. The door leading to the supply closet in the basement was observed to be missing a window pane. 4. The bathroom located in the basement was observed to have stained and old sheet rock above that was drooping from it's original foundation. 5. There blinds attached to the side door in the living room area was damaged. The blinds attached to the front door was also observed to be damaged. Exterior 6. The front yard and both basement exits were littered with debris, old paint cans, and trash.	I 090	3504.1 1. The cabinet drawer was replaced…1-2-08. 2. The sink was sanded and repainted…1-23-08. 3. The window pane was replaced…1-22-08. 4. The sheet rock was removed and the area repaired by…1-23-08. 5. The front door blind was replaced by…1-19-08. the side door blind will be replaced by…1-30-08. 6. The yards debris and trash will be removed by…1-28-08. The residence manager will conduct routine, weekly audits of the physical environment and will report her findings to the residential director for follow up…2-1-08.	
I 135	3505.5 FIRE SAFETY Each GHMRP shall conduct simulated fire drills in order to test the effectiveness of the plan at least four (4) times a year for each shift. This Statute is not met as evidenced by: Based on staff interview and record review, the GHRMP failed to hold evacuation drills quarterly on all shifts and under varied conditions. The findings include:	I 135		

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I 135	Continued From page 2 1. Interview with the House Manager (HM) and review of the staffing pattern on December 27, 2007 at approximately 11:15 AM revealed the scheduled shifts are as follows: Weekdays 1st Shift 12 AM to 8 AM 2nd Shift 8 AM to 4 PM 3rd Shift 4 PM to 8 PM Weekends/Saturday and Sunday 1st 8 AM to 8 PM 2nd 8 PM to 8 AM Further interview with the HM revealed that the staff was required to conduct a drill once per month on each shift. Review of the fire drill log book from January 2007 to December 2007 28, 2007 revealed that the facility failed to hold fire evacuation drills for the second shift on the weekdays. There was no evidence that fire drills were conducted quarterly on all shifts. 2. Review of the facility's fire drill records on December 27, 2007 at approximately 11:34 AM revealed that most of the fire drills were conducted via the front and back door exits. Interview with the Qualified Mental Retardation Professional (QMRP) and HM on December 28, 2007 at approximately 2:28 PM revealed that the facility had at least five method of egress. Further interview with the HM revealed that there's an exit through the laundry room in the basement which had a lock on the door. Interview with the direct care staff during the environmental walk-thru revealed that the residents never use this exit during fire drills. Further review of the fire drill record revealed that the exit through the laundry located in the	I 135	3505.5 1. The residential director has developed a universal fire drill schedule for 2008 that ensures (if properly implemented) that all shifts have drills each quarter. The QMRP will monitor implementation of the fire drill schedule routinely and will insure that any drill missed for any reason is made up within seven days for the targeted shift...2-1-08. 2. The fire safety consultant will conduct training with staff on all fire safety issues including the proper use of all exits during drills...2-15-08. The facility manager will review all fire drill documents to insure that staff routinely follows best practices...2-1-08.	

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I 135	Continued From page 3 basement had not been used. There was no evidence that evacuation drills were held under varied conditions.	I 135		
I 206	3509.6 PERSONNEL POLICIES Each employee, prior to employment and annually thereafter, shall provide a physician ' s certification that a health inventory has been performed and that the employee ' s health status would allow him or her to perform the required duties. This Statute is not met as evidenced by: Based on interview and record review, the GHMRP failed to ensure that all staff had current health certificates on file. The findings include: 1. Review of the personnel files conducted on 12/19/07 at approximately 10:29 PM revealed the GHMRP failed to provide evidence of current current health certificates for two of eight staffs. (S#2 had no current physical and the Facility's Manager health certificate was expired) 2. Review of the personnel files conducted on 12/28/07 at approximately 10:23 AM revealed the GHMRP failed to provide evidence of current current health certificates for four consultants. (C #3, C #5, C #7, C#11 and C #12)	I 206	3509.6 1. All staff members have current health certificates (see attachments)...1-25-08. 2. All consultants have been contacted and will provide updated documents by.....2-15-08. The QMRP and/or facility manager will audit the records quarterly in order to insure routine compliance and proactive notification for staff and consultants...2-1-08.	
I 227	3510.5(d) STAFF TRAINING Each training program shall include, but not be	I 227		

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I 227	Continued From page 4 limited to, the following: (c) Infection control for staff and residents; This Statute is not met as evidenced by: Based on record review, the GHMRP failed to have on file for review current training in first Aid and CPR for employees. The findings include: On 12/28/07 at approximately 10:23 AM, review of personnel records/training records revealed that the following staffs was without current First Aid and CPR, or both. 1. Current CPR - S#8 2a. First Aid - C #2, C #11, and C #12 b. CPR - C #2, C #3, C #11, and C #12	I 227	3510.5 All staff has current CPR and first aid. They are trained concurrently (see attachments)…1-25-08. MTS will hold a training session for its nurses who do not have current CPR and first aid by…2-15-08.	
I 391	3520.2(a) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by District of Columbia law in the following disciplines or areas of services: (a) Medicine; This Statute is not met as evidenced by: Based on staff interview, and record review the	I 391		

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I 391	Continued From page 5 GHMRP failed to order laboratory studies on two of three residents in the sample who is on anti-convulsant medications. (Resident #1) The finding includes: Observations of the evening medication administration on 12/27/07 at 5:08 PM revealed Resident #1 was administered Risperdal 3 mg, and Carbamazepine 200 mg 3 tabs, by mouth. Review of Resident #1's medical records on 12/27/07 at approximately 12:38 PM revealed current Physician's Orders (PO) dated December 2007. According to the PO's, Resident #1 has diagnosis of Seizure Disorder and is prescribed Fluoxetine HCL 40 mg every day for movement disorder. Interview with the nursing staff on 12/27/07 at approximately 5:12 PM revealed that Resident #1 is administered the anti-convulsant medications for seizure management. There was no documented evidence that the physician ordered laboratory studies to monitor the client's anti-convulsant medications listed on the current PO's. Interview with the Director of Nursing (DON) on December 28, 2007 at approximately 3:00 PM acknowledged that labs were not listed on Resident #1's PO's.	I 391	3520.2(a) As indicated by the surveyor, the lab work required was not listed on the physician's orders but it was done. The physician's orders have been updated to reflect the needed serum lab follow up...1-25-08. In the future, the lead nurse will insure all such needed modifications are made during the nurse/physician meetings or by the nurse based on verbal approval by the PCP...1-30-08.	
I 395	3520.2(e) PROFESSION SERVICES: GENERAL PROVISIONS Each GHMRP shall have available qualified professional staff to carry out and monitor necessary professional interventions, in accordance with the goals and objectives of every individual habilitation plan, as determined to be necessary by the interdisciplinary team. The professional services may include, but not be limited to, those services provided by individuals trained, qualified, and licensed as required by	I 395		

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I 395	Continued From page 6 District of Columbia law in the following disciplines or areas of services; (e) Nursing; This Statute is not met as evidenced by: Based on staff interview and record review the facility failed to ensure nursing services in accordance with the needs of two of three residents in the sample. (Resident #1 and #3) The findings include: 1. The facility's nursing services failed to ensure that Resident #1 Abnormal Involuntary Movement Scale (AIMS) was updated and failed to ensure that Resident #1's allergies and weekly shots was listed on current Physician's Orders as evidence below: a. Observations of the evening medication administration on 12/27/07 at 5:08 PM revealed Resident #1 was administered Risperdal 3 mg, and Carbamazepine 200 mg 3 tabs, by mouth. Review of Resident #1's medical records on 12/27/07 at approximately 12:38 PM revealed current Physician's Orders (PO) dated December 2007. According to the PO's, Resident #1 is prescribed Fluoxetine HCL 40 mg every day for movement disorder. Further review of Resident's #1 medical records revealed an Abnormal Involuntary Movement Scale (AIMS) last dated 2/12/07. Interview with the facility's RN on December 28, 2007 at approximately 1:00 PM revealed that the AIMS exams are usually conducted every six months. Further interview with the RN acknowledged that another AIMS exam was due for Resident #1. At the time of the survey, there was no evidence that the RN had completed an updated AIMS exam for Resident	I 395	3520.2(e) 1a. An Aims review will be completed by the RN for resident #1 by…1-30-08 and will be added to the HRMCP so that routine follow up parameters are effectively tracked……..2-1-08. b. The required weekly shots are given routinely, however the PO's do not reflect the treatment regimen as indicated by the surveyor. The PO's will be modified by……1-26-08.	

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I 395	Continued From page 7 #1. b. Review of Resident #1's medical records on 12/27/07 at approximately 1:10 PM revealed a nursing assessment dated 1/16/07. According to the assessment Resident #1 is allergic to Shellfish and Iodine. Further review of the medical records revealed that Resident #1 receives weekly shots for allergy. Interview with the Facility's RN on 12/28/07 at approximately 11:38 PM confirmed that Resident #1 takes weekly shots for allergies. Review of the current PO's dated December 2007 revealed that "Allergies" was not on the listed PO's. Further review of the PO's failed to evidence that Resident #1 takes weekly shots for allergies. Further interview with the RN acknowledged that information is very important and should be listed on the PO's. 2. The facility's nursing services failed to ensure that Resident #3's recommended BSER Evaluation had been completed and failed to ensure the nutritionists recommendations had been implemented as evidence below: a. Review of Resident #3's medical records on 12/27/07 at 2:06 PM revealed a medical consult dated 3/14/07. According to the consult, Resident #3 had an audiological exam completed and recommended the following: 1. ENT consult for cerumen removal of the left ear and right ear bilaterally. 2. Audio re-evaluation following ENT consult for the removal of cerumen. BSER Evaluation - Threshold search to determine hearing status. Interview with the facility's RN on 12/28/07 at approximately 12:00 PM was not sure if the	I 395	3. ENT has been scheduled for resident #3 to remove ear wax…2-8-08 and the needed Audio has been scheduled thereafter for…3/08.	

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I 395	Continued From page 8 recommendations had been scheduled or completed. The RN stated that she was hired by the facility after the recommendations. The RN further stated that the House Manager would know if the recommendations had been completed. Interview with House Manager at approximately 3:00 PM revealed that the recommendations had not been completed. At the time of the survey, there was no documented evidence that the recommendations made by the audiologists had been completed. b. Review of Resident #3's medical records on 12/27/07 at approximately 2:06 PM revealed a Nutritional Assessment dated 8/23/07. The nutritional assessment recommended that Resident #3 receive "double-portions" at breakfast. Review of the current PO's dated December 2007 revealed a diagnosis of "Chronic Weight Loss". Interview with the facility's RN on 12/28/07 at approximately 11:40 AM revealed that she had not discussed this recommendation with nutritionist. The RN stated that she would have to follow up with the nutritionist to clarify her recommendation. There was no documented evidence that the nutritionist recommendations had been implemented.	I 395	b. The double portions breakfast diet was recommended by the nutritionist for resident #3 but not discussed with the PCP or lead RN. Additionally no modified menus were developed. The QMRP will coordinate a follow up discussion between himself, the lead RN, PCP and nutritionist to finalize plans for the double portions breakfast diet which will begin thereafter by...2-15-08.	
I 420	3521.1 HABILITATION AND TRAINING Each GHMRP shall provide habilitation and training to its residents to enable them to acquire and maintain those life skills needed to cope more effectively with the demands of their environments and to achieve their optimum levels of physical, mental and social functioning. This Statute is not met as evidenced by: Based on interview, and record review, the Qualified Mental Retardation Professional	I 420		

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I 420	Continued From page 9 (QMRP) failed to ensure the coordination of services for one of three residents in the facility. (Resident #2) The finding includes: The QMRP failed to coordinate services with Resident #2's day program to ensure the Speech/Language recommendations was addressed as evidenced by: Review of the Speech/Language assessment dated 12/11/06 on December 27, 2007 at approximately 2:06 PM revealed the following recommendation: The day program should create a communication book or wallet that Resident #2 can use at the day program as well as in her group home. Interview with the QMRP on 12/28/07 at approximately 2:40 PM revealed that Resident #2 receives Speech/Language services one hour a week. The QMRP further revealed that the recommendation had not been addressed. The QMRP stated that he would follow up with the Speech/Language Pathologists. There was no documented evidence that the Speech/Language recommendations had been addressed.	I 420	3521.1 The QMRP will meet with the day program of client #2 and share the citation with its staff. The program will be asked to develop a communications book with input from the QMRP. The book will be developed by the day program speech pathologist and will be completed by…2-15-08.	

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R 000	INITIAL COMMENTS A licensure survey was conducted from December 27, 2007 through December 28, 2007. A random sample of three residents were selected from a population of five females with various disabilities. The findings of this survey were based on observations at the group home, interviews with one resident and group home staff, review of clinical and administrative records to include the facility's unusual incident reports and investigations.	R 000		
R 125	4701.5 BACKGROUND CHECK REQUIREMENT The criminal background check shall disclose the criminal history of the prospective employee or contract worker for the previous seven (7) years, in all jurisdictions within which the prospective employee or contract worker has worked or resided within the seven (7) years prior to the check. This Statute is not met as evidenced by: Based on the review of records, the GHMRP failed to ensure criminal background checks for the previous seven (7) years, in all jurisdictions where staff had worked or resided within the seven (7) years prior to the check for one of staff. The finding includes: Review of the review of personnel files on December 28, 2007 at approximately 10:23 AM revealed the GHMRP failed provide evidence of a criminal background checks for the previous seven years in all jurisdiction where one direct care staff had worked or resided. (Staff #2 for the	R 125	4701.5 All staff have Global criminal background checks (see attachments)...1-25-08.	

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R 125	Continued From page 1 state of Maryland)	R 125		